SUPERIOR VISION

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

GROUP VISION APPLICATION

Administered by: **Superior Vision Services, Inc.**
11101 White Rock Road
Rancho Cordova, CA 95670

Group Effective Date: _____, _____ Group No. **33664**

Legal Group Name **City of Durham** Tax ID Number _____

Physical Address _____ ERISA Number _____

City \ State \ Zip _____ SIC \ Industry _____

Billing Address _____ # of Employees _____

City \ State \ Zip _____ # of Eligible _____

Eligibility Contact _____ Phone _____ Fax _____

Billing Contact _____ Phone _____ Fax _____

Initial Premium Rates:

Employee Only $ _____ **Employee + Spouse** $ _____ **Employee + Child(ren)** $ _____ **Employee + Family** $ _____

Initial Guarantee Period: Premiums are not guaranteed beyond the below date.

_____, _____ through _____, _____

Eligibility data will be submitted using:

☐ **National Guardian enrollment forms**
☐ **Email or electronic media (Employer must keep signed enrollment forms on file for future reference.)**

Eligibility: Employees working _____ hours per week will be effective for coverage upon: ☐ 30 Days ☐ 60 Days ☐ 90 Days

☐ 1st of the month following _____ days ☐ Other _____

An eligible Dependent must be less than ____ years old or less than ____ years old if a full-time student.

Participation:
Depending on group size and coverage elected, specific participation requirements may apply. Participation must be met before the insurance can be effective and must be maintained continuously while insurance is in force to prevent cancellation of coverage. I understand and agree that audits will be made by National Guardian Life Insurance Company now and in the future to verify the number and names of employees of this group. I will furnish with application and upon any future request any other information requested.

Please send Membership Materials and Enrollment Materials to (CHECK ONE):

☐ Group Attn: _____ Phone _____ Email _____

☐ Agent _____ Phone _____ Email _____

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for each employee benefit plan. I understand and agree if, on the effective date, an employee is not in permanent full-time active work or unable to perform usual and customary duties, coverage will not be effective until the employee returns to an active eligible status. I hereby certify that the information provided herein is true and complete to the best of my knowledge and that I have read and understand this form.

The information contained herein describes the essential provisions of the elected coverage(s) discussed between the above client and an authorized National Guardian Life Insurance Co. representative. By signing this form, both parties agree that these are the essential provisions the client is purchasing. The details of this form may be changed by either party with mutual agreement.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION TO OBTAIN INSURANCE IS GUILTY (IN TEXAS AND KANSAS MAY BE GUILTY) OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signed: _____ Date: _____

Print Name: _____ Title: _____

National Guardian Representative: _____ Date: _____

See reverse side

Agent	Tax I.D. #
Agency	Phone
Address	Fax
City/State/Zip	Email

National Guardian Life Insurance Company appointment on file: ☐ **Yes** ☐ **No** ☐ **Pending** ☐ **N/A**

See reverse side